

Integrating Family Planning into Primary Health Care in Ghana

A CASE STUDY

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Acknowledgments

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Introduction

This case study was produced as part of a project funded by the Bill & Melinda Gates Foundation called Integrating Vertical Programs into Primary Health Care Systems. The project tests a technical approach that policymakers can use to understand how a vertical, or health need–specific, program is structured and to what extent it is integrated with the larger primary health care (PHC) system.¹ In this case study, we examine key considerations related to integrating family planning services into Ghana’s PHC system.

We have combined a desk review of key documents with insights gained from interviews with health sector experts in Ghana to describe how family planning services are currently delivered in Ghana, the degree to which they are integrated with the PHC system, the actors involved, and their dynamics. The case study is intended to help policymakers in Ghana set priorities, identify where further integration would be beneficial, and select methods for increasing integration.

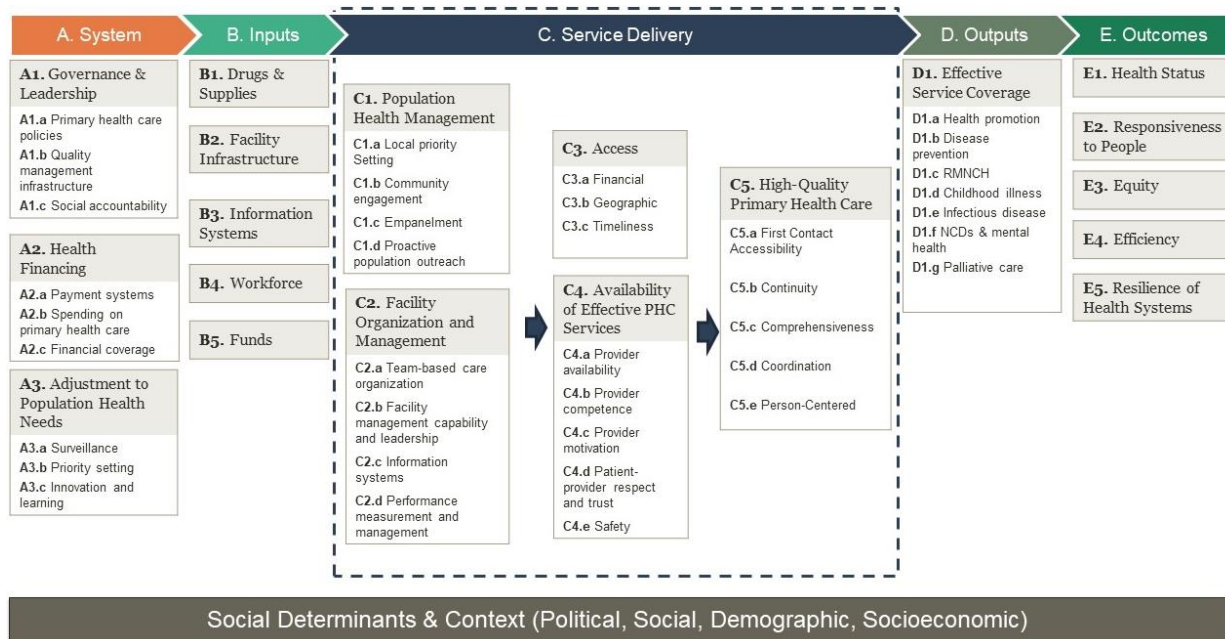
We define *integration* as the process by which a disease- or health need–specific program comes to share more of its components, or share them more fully, with the broader health system. Integration can be as simple as shifting from disease-specific facilities to multi-purpose facilities. Or it can be as complex as a thorough reorganization of financing, supply chains, and service delivery, especially in anticipation of the phasing out of donor funding.

Central to our project’s overall technical approach is the PHC Conceptual Framework created by the Primary Health Care Performance Initiative (PHCPI).² (See Figure 1.) This framework provides a way to identify and understand the components and functions of a PHC system and guide decision-making discussions between governments and donors.*

Our project hypothesizes that the PHC Conceptual Framework also applies to many, if not all, components and functions of vertical programs. We tested this hypothesis by examining the family planning program in Ghana. By doing so, we gained useful insights into where the vertical program is already integrated with PHC, as well as areas that will require special attention if further integration is to occur without sacrificing quality of care.

* Even greater disaggregation may be desirable at times, such as when independently analyzing the three Financing functions—revenue mobilization, pooling, and purchasing (Blanchet et al., 2014).

Figure 1. The PHC Conceptual Framework



Note: This figure is reproduced from the PHCPI website. The dotted line surrounding Service Delivery is part of the original figure and has no specific meaning in this paper.

Methodology

To test the usefulness of the PHC Conceptual Framework in mapping the current level of integration of family planning and PHC in Ghana, we reviewed key documents—government strategies, survey reports, program reports, and scholarly articles—about the current level of integration and the future direction of the family planning program in Ghana. We also interviewed nine experts using a semi-structured discussion guide, which we continually adapted to reflect emergent areas of information and to better target questions to each interviewee’s area of expertise. We transcribed the interviews and coded the content using the subdomains of the PHC Conceptual Framework. Doing so helped us test the usefulness of the framework for categorizing and organizing insights revealed in the interviews.

Family Planning Policy and Integration Planning in Ghana

Ghana is a lower-middle-income country that has made admirable progress in PHC service delivery and financing.³ The government has long been committed to having a strong family planning program as an essential component of Ghana’s broader development agenda. This was made explicit in a 1969 policy statement titled “Population Planning for National Progress and Prosperity,” which identified family planning programs as crucial to ensuring good quality of life for all Ghanaians.⁴

Leading up to the revision of this policy in 1994, the government created the National Population Council in 1992, formalizing it in 1994. This body is located in the Office of the President and has the explicit mission to provide guidance “on population and related issues, and to ensure that population considerations remain central to development planning.”⁵ The role of family planning in Ghana’s larger development agenda is apparent in other broad policy and strategy documents such as the *Ghana*

Shared Growth and Development Agenda (GSGDA) II, 2014–2017 and the Health Sector Medium Term Development Plan 2014–2017.^{6,7}

Family planning is already integrated into many aspects of the Ghanaian PHC system. Most notably, family planning was one of the original functions of the Community-based Health Planning and Services (CHPS) program, which was created to expand access to basic health care in rural and underserved communities. The current family planning strategy proposes more integration with PHC and integration of different components.

The interviews confirmed that integration happens along a continuum: it is not an all-or-nothing or all-at-once shift. They also revealed that health policymakers do not always share a common working definition of integration.

The desk review and interviews revealed that some elements of the vertical program are critical to delivering high-quality family planning services and must be preserved, augmented, or improved as part of any integration effort. These include specific system requirements, inputs, and standards for service delivery. Figures 2 and 3 show some of the critical aspects of the family planning program that must be factored into decision-making about where and how to further integrate with PHC.

Figure 2. Important Considerations for Family Planning in the PHC System and Inputs Components

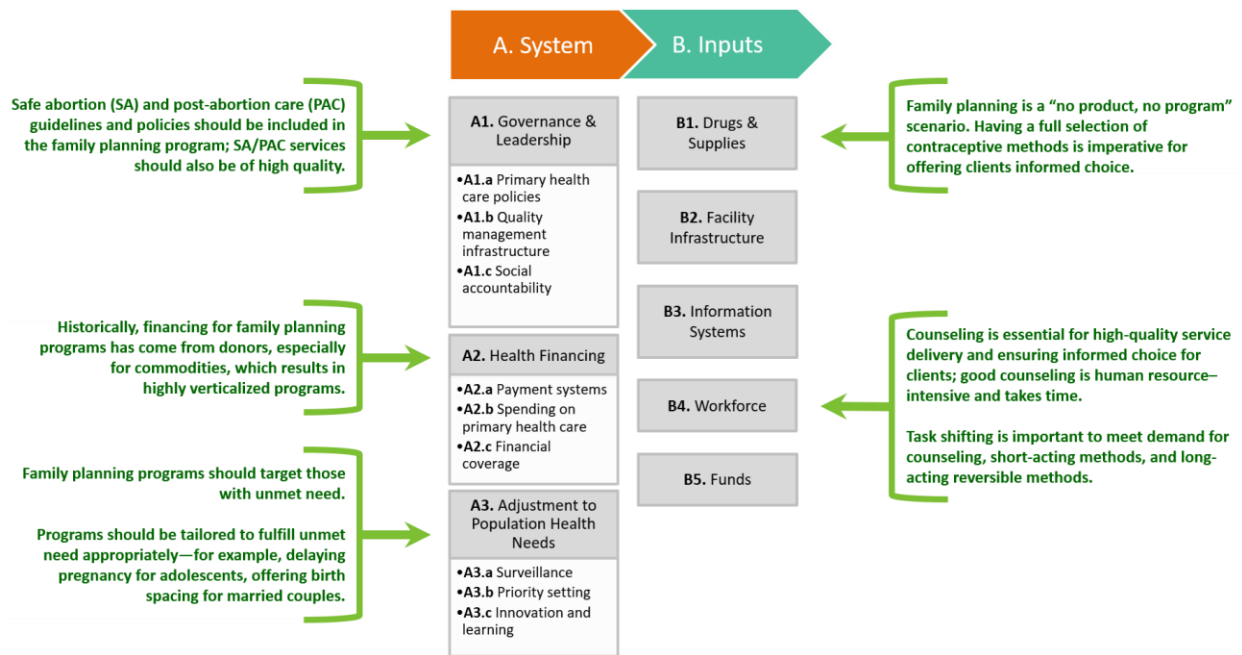
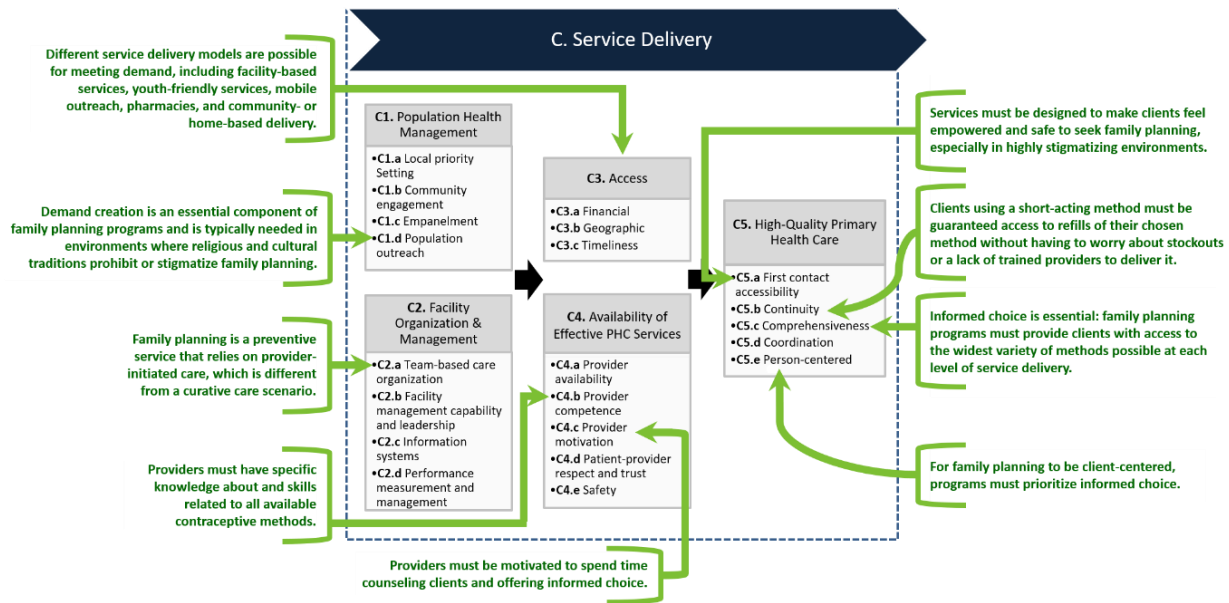


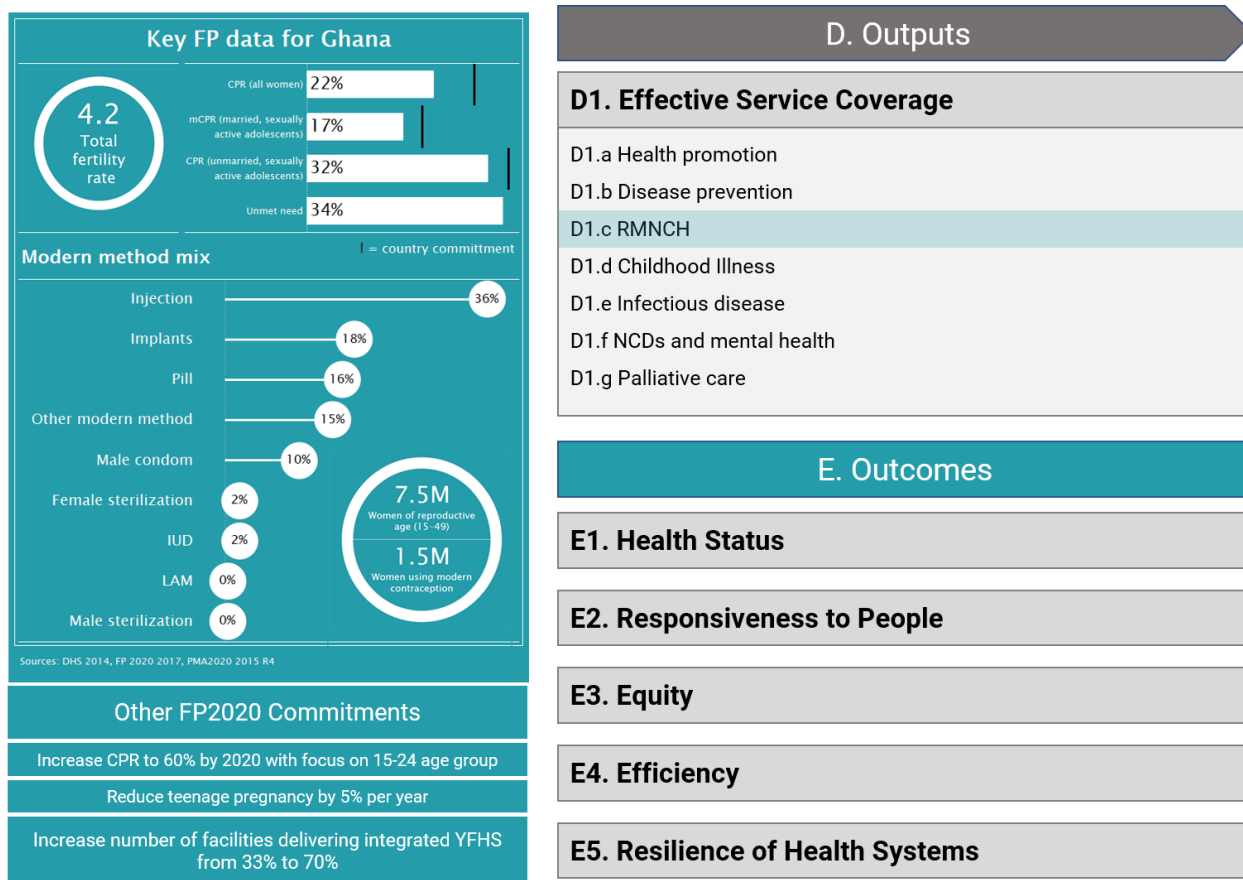
Figure 3. Important Considerations for Family Planning in the PHC Service Delivery Components



The government believes that further integrating the vertical program with PHC will increase family planning coverage and result in cost savings within the overall health system. Health indicators tracked by the government show that family planning coverage in Ghana lags behind the government’s stated goals, including the FP2020 commitments it made at the 2012 London Summit on Family Planning.⁸ The modern contraceptive prevalence rate (mCPR) in Ghana is 22%, short of the country’s FP2020 commitment to increasing mCPR to 29%. The government has also committed to incorporating clinical family planning methods as a covered benefit under the national health insurance scheme and increasing its contribution to the purchasing of contraception commodities from one-quarter to one-third.⁹

Figure 4 shows how Ghana’s current performance measures and FP2020 commitments for family planning map to the Outputs and Outcomes columns in the PHC Conceptual Framework.

Figure 4. Mapping FP2020 Commitments to the PHC Conceptual Framework



As part of its FP2020 commitments, the government approved the *Ghana Family Planning Costed Implementation Plan 2016–2020* (GFPCIP), which outlines strategies for improving sexual and reproductive health. The plan also notes the importance of integrating family planning into the PHC system and other vertical programs—such as maternal and child health services, antiretroviral therapy (ART) clinics, and client-initiated HIV testing—to improve efficiency and yield financial savings on the way to meeting the FP2020 commitments.¹⁰

Using the PHC Framework to Understand the Vertical Program

The following sections apply the PHC Conceptual Framework in describing Ghana’s family planning program and its relationship to the PHC system.

A. System

A1. Governance & Leadership

All national and subnational family planning efforts in Ghana operate in a policy and legal environment in which provision of family planning is legal. Married and unmarried adolescents and adults can access services without permission from a parent or a spouse. Induced abortion is legal in cases of life endangerment, fetal anomaly, rape or incest, or to protect the physical and/or mental health of the pregnant woman. The inclusion of mental health in this list means that abortion is theoretically

attainable for most women who seek abortion services, although many women are not aware of this policy.¹¹

Ghana Health Service (GHS), an agency within the Ministry of Health, owns the family planning program. The program is overseen by the Family Health Division, a functional division within GHS. Responsibilities for program operation further cascade down to regional health management teams and district health management teams, which coordinate inputs and service delivery at subnational levels.¹² While ownership of the family planning program resides with the government, international donors such as the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) have significant influence over the direction of the program because of the funds they contribute for service delivery and commodities.

Family planning services are included in the main PHC structure in Ghana, both through health facilities and through the CHPS strategy, which grew out of a pilot program launched in 1998 to provide family planning and other basic PHC services to rural and underserved areas.¹³ The program places community health nurses (CHNs) in hard-to-reach communities and uses a network of community health volunteers (CHVs) to expand access to health care. CHNs recruit and manage CHVs, and CHVs help with community engagement and health promotion.¹⁴ For family planning, these volunteers can provide condoms and information on other available methods. However, the program has been plagued by high turnover among staff and volunteers.

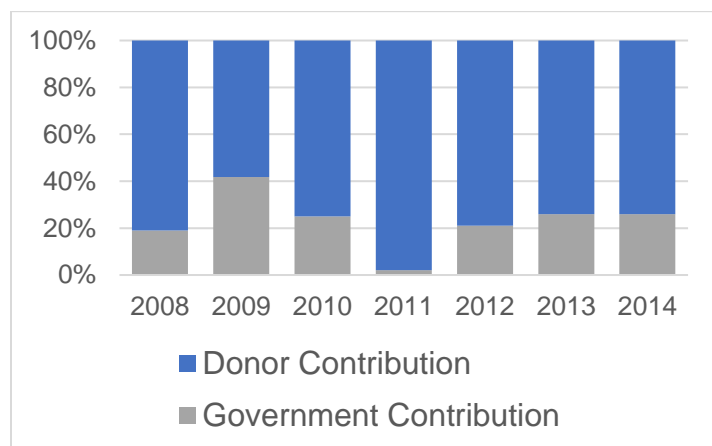
GHS is also responsible for supervising accreditation of health facilities, paying staff salaries at public health centers, and leading supportive supervision for health workers. In October 2017, GHS launched new supportive supervision guidelines and a strategy for addressing criticism that the previous supportive supervision structure was inadequate.¹⁵ The GFPCIP emphasizes the need for continuous provider training and supportive supervision, especially among lower cadres of health workers, to ensure that family planning services are provided in accordance with GHS guidelines.

One notable gap in the GHS mandate on guiding and supervising health services is the lack of private-sector involvement. The private sector, including actors such as the Christian Health Association of Ghana and Marie Stopes International, provides approximately one-third of family planning services in Ghana but is not well incorporated into the health system or well regulated by the government.¹⁶ One exception is the Christian Health Association of Ghana, a network of 302 faith-based health facilities that works closely with the Ministry of Health to provide health care in underserved areas and implement programs.¹⁷ This leaves the private sector largely excluded from access to subsidized family planning commodities, accreditation, and the GHS supervision structure.

A2. Health Financing

As a lower-middle-income country that rose out of the low-income category in 2010, Ghana still relies on donor funding for a significant portion of its health budget, especially for family planning service delivery and commodities, which are distributed to public-sector facilities. (See Figure 5.) The World Bank currently funds some family planning services at the PHC level, but this funding goes only to public providers; these providers tend to use the funds to offer short-acting contraceptive methods because these methods are generally cheaper. As the government considers further integration of family planning into the PHC system, it must consider the costs, who pays those costs, and the tradeoffs that accompany different reimbursement structures.

Figure 5. Funding Sources for Family Planning Commodities



Source: GFPCIP

In 2003, Ghana officially launched the National Health Insurance Scheme (NHIS), which is run by the National Health Insurance Authority (NHIA). The NHIS provides social insurance for a package of preventive and curative services. Funds for the NHIS come mostly from an earmarked portion of Ghana's value-added tax (called the National Health Insurance Levy), a portion of pension contributions by some formal-sector workers, and smaller funding sources such as donor contributions and investment income. The NHIS also charges very low premiums (currently about US\$7 per year) to informal-sector members, and these are waived for large categories of high-need individuals. As of 2014, the NHIS covered approximately 40% of Ghanaians.¹⁸

Public, private, and NGO providers are all eligible to be accredited as service providers within the NHIS. NHIS enrollees may access services at any accredited site without a copay, and accredited providers are reimbursed for services delivered.

Family planning services were excluded as a covered benefit during the initial NHIS law passed in 2003 because donors heavily funded programs, and especially commodities. During the revision of the NHIS law in 2012, family planning services were theoretically included in the benefits package because they were placed under the direction of the minister for health, but the implementation of this policy shift has stalled, mostly due to difficulties in negotiating the reimbursement structures for family planning. As part of its FP2020 commitments, the government said it would recalibrate the health system to function without the same levels of donor funding and would ensure that family planning is covered under the NHIS.

In May 2018, the NHIA, with the support of several partners, began a pilot program in selected districts to evaluate the effectiveness of providing family planning under the NHIS. The most critical element of the pilot is the issue of provider reimbursement: whether to use capitation (paying providers an agreed-upon amount per person for a specific set of PHC services, including family planning), bundled payment (covering an episode of family planning counseling, method provision, and follow-up), or fee-for-service (reimbursing providers after the fact for each service they provide). Capitation has proven to be challenging for the NHIS to implement due to resistance on the part of providers, who feel that it does

not adequately reimburse them for their service delivery costs.¹⁹ Many key donors and some implementing partners, however, favor capitation over fee-for-service as a more sustainable solution.

As one interviewee noted, both methods present risks. Under capitation, providers tend to limit the services they provide because they receive only a one-time payment. With fee-for-service, providers have an incentive to provide more services, with a bias toward prescribing short-acting contraceptive methods, which require clients to return for refills or additional injections. However, if payments for long-acting and permanent contraceptive methods are set too high under a fee-for-service system, this could shift the bias toward overprovision of long-acting contraceptive methods. The interviewee noted that the pilot program will be useful in costing services for providers, clients, and insurers, and to identify which provider payment mechanisms will work best.

Another interviewee noted that family planning is a tricky area when it comes to NHIS coverage because the issue is not who pays for the commodities but who pays for the additional time spent by providers. That is, family planning services must be accompanied by rights-based informed consent and counseling, which is time-consuming. Accounting for this time will be an important consideration for reimbursements, including whether reimbursement structures for counseling will be the same as those for providing family planning commodities. Currently, R4D is coordinating an actuarial study to determine the costs to the NHIS of different PHC packages (including family planning).

A3. Adjustment to Population Health Needs

A key priority for the Ghanaian government is to reach those most in need of health care. For family planning, this means offering services where unmet need is highest, especially in certain regions (such as the Volta, Eastern, and Ashanti regions) and among those of lower socioeconomic status and adolescents and youth.²⁰ Strategies for reaching those with greatest unmet need for family planning include NHIS subsidies, covering family planning as a benefit under the NHIS, and using the CHPS strategy to reach rural and other hard-to-reach populations.²¹ The government has also approved an adolescent- and youth-responsive health services strategy²² and created multiple strategies in the GFPCIP to increase youth access to family planning services.

B. Inputs

B1. Drugs and Supplies

Commodity availability is critically important for family planning programs because true informed choice can be provided only when all methods are available. External donors still fund most contraceptive commodities in Ghana, which helps ensure choice in the public sector. However, the system for ordering and delivering contraceptives is different for the private sector; this limits choice in private-sector facilities and makes it difficult to forecast contraceptive commodity needs for the country.

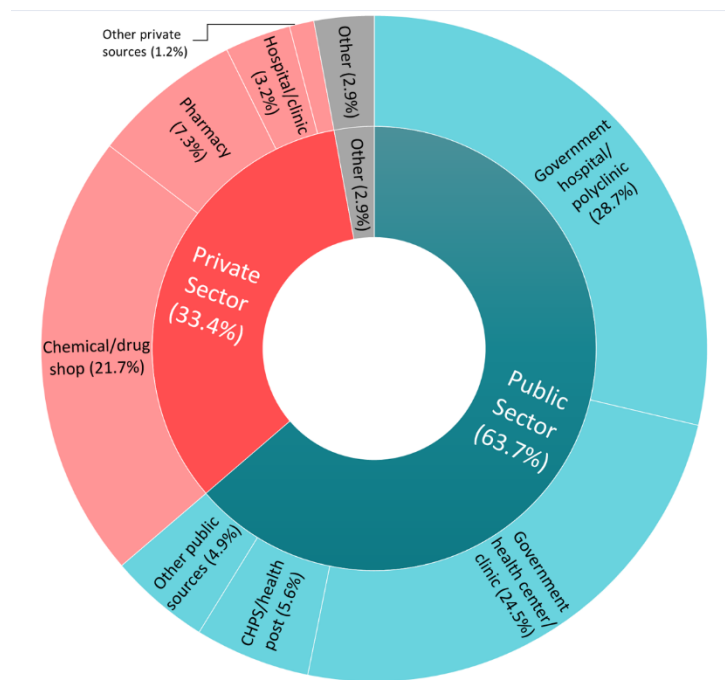
In the public sector, contraceptive commodities, like other health commodities, are distributed through regional warehouses. Supplies at the central level are reasonably stable. Despite reports of stockouts at the facility level, the GFPCIP deems most of these stockouts “artificial” and attributable to poor information systems and misdistribution rather than true stockouts at the central or regional level. In the latest Performance Monitoring and Accountability 2020 (PMA2020) survey, stockout rates for specific commodities at public facilities in Ghana rarely exceed 10%.²³

Private-sector facilities receive commodities through commercial suppliers. The method mix provided at private facilities is much more limited than those at public facilities, particularly for long-acting reversible methods. Less than a quarter of private facilities offer intrauterine devices (IUDs) or implants, and less than a third provide injectables. Lack of contraceptive choice in the private sector is due to a variety of factors. Many private facilities are pharmacies or drug shops, which are not authorized to insert or remove IUDs or implants. Also, many private facilities must contract with private pharmaceutical importers to purchase commodities, and IUDs and implants do not provide a sufficient return on investment to be worth purchasing.²⁴ Stockout rates for the short-acting methods that private providers tend to offer—such as oral contraceptives, condoms, and injectables—are low.²⁵ Although the private sector provides approximately 33% of family planning services in Ghana,²⁶ it has historically been excluded from procurement planning for national family planning efforts. The GFPCIP identifies this as a key area to be addressed to improve contraceptive security. In addition, GHS does not publish reliable data on the number or type of private facilities or the number of private providers nationwide. This limits data flows and insight into the types of methods offered to private-sector clients.

B2. Facility Infrastructure

Ghana has made a notable effort to include family planning as part of routine care offered at facilities. The latest PMA2020 data show that 100% of public facilities and 82% of private facilities offered family planning as part of their package of care. (See Figure 6.) Ghana also continues to invest in the CHPS strategy to ensure that rural and hard-to-reach populations have access to family planning services as part of a basic PHC package.

Figure 6. Source of Most Recent Modern Contraception Method Among Women Ages 15 to 49



Note: The “Other” category includes friends, relatives, unknown sources, and missing data. “Other public sources” include family planning clinics, mobile clinics, and field/outreach/peer educators. “Other private sources” include family planning clinics, Planned Parenthood Association of Ghana clinics, and maternity homes.

Source: Ghana Demographic and Health Survey 2014

Table 1 provides a breakdown of family planning services delivered through Ghana’s public sector.

Table 1. Family Planning Services Delivered Through the Public Sector

	Care Level	Type of Service Delivery Point	Methods Offered	% of Family Planning Services Delivered Nationwide	# of Service Delivery Points
TOWARD THE COMMUNITY LEVEL	Tertiary Care Secondary Care Primary Care	Hospitals/polyclinics	Permanent methods* IUDs Implants Injectables Oral contraceptive pills Condoms	28.7%	166
	Secondary Care Primary Care	Health centers/clinics	*if appropriate cadre is available	24.5%	1,774
	Primary Care	CHPS compounds	IUDs* Implants Injectables Oral contraceptive pills Condoms *if appropriate cadre is available	5.6%	3,335
		Community health volunteers	Oral contraceptive pills* Condoms *if a refill for previous prescription	no data available	no data available

Adapted from Ghana Demographic and Health Survey 2014 and The Health Sector in Ghana: Facts and Figures—2016, 2017

B3. Information Systems

Information systems for tracking family planning service delivery in Ghana are largely vertical, and the data are of variable quality. Incongruities also exist between paper-based reporting systems and aggregate data reported at the national level through DHIS2, the data management platform used by the government. Data on quality are usually lacking altogether.

Interviewees described the lack of data integration and noted the existence of commodity and service delivery registers and separate data reporting structures “not only for family planning but basically for all services.” This increases the workload for health facility staff, and providers see this duplicative bookkeeping as a burden.

Discrepancies in reporting are also notable between services delivered on the ground and national-level figures. Since many service delivery points in Ghana—especially CHPS compounds—do not have access to electricity, routine data must be collected using paper-based registries.²⁷ Facility-specific data are supposed to be sent to the national level, to be aggregated in DHIS2. But national-level figures end up incomplete when public and private facilities fail to report their service delivery numbers.²⁸

One interviewee noted that when the NHIS pilot-tested capitated payments to providers from 2012 to 2017, provider utilization reports were lacking. If the NHIS moves to a capitated model of reimbursement, this could present a challenge for understanding family planning service utilization.

Historically, Ghana’s supportive supervision and data reporting for family planning services and data reporting have been insufficient to lend insight into the quality of services delivered on the ground. As a result, quality measures are lacking and the systems to improve service delivery, such as mentorship, are not implemented.

B4. Workforce

Most of Ghana’s clinical workforce is made up of CHNs that operate at CHPS compounds. Turnover is high among CHNs and CHVs, which limits the availability of family planning counseling and method provision at the most basic level of care. In addition, an insufficient number of clinicians and midwives are available to provide long-acting contraceptive methods, specifically implants and IUDs, which can be complicated to insert and remove and therefore require additional training. (See Table 2.)

Table 2. Family Planning Workforce and the Methods They Are Authorized to Provide

Cadre	Number Specializing in Reproductive Health (nationwide)	Family Planning Methods They Are Authorized to Provide
Clinicians/physicians (including OB/GYNs and pediatricians)	652	Permanent methods, IUDs, implants, injectables, pills, condoms
Public health nurses	327	IUDs, implants, injectables, pills, condoms
Practicing midwives	2,223	IUDs, implants, injectables, pills, condoms
Community health nurses (CHNs)*	7,211	Implants, injectables, pills, condoms
*Community health volunteers (CHVs) work with CHNs to conduct community outreach. They can provide family planning counseling, condoms, and refills of previously prescribed oral contraceptive pills.		

Source: Ghana Family Planning Costed Implementation Plan, 2016-2020

To address this issue, Ghana has instituted a task-shifting strategy to ensure that lower-cadre workers are trained to provide long-acting contraceptive methods. For example, CHNs can now provide and remove implants.²⁹ One interviewee noted that midwives at CHPS sites are also able to provide IUDs and that efforts are underway to train CHNs to provide IUDs. Task shifting presents one of the most promising strategies to increase family planning coverage and integrate family planning into PHC.

B5. Funds

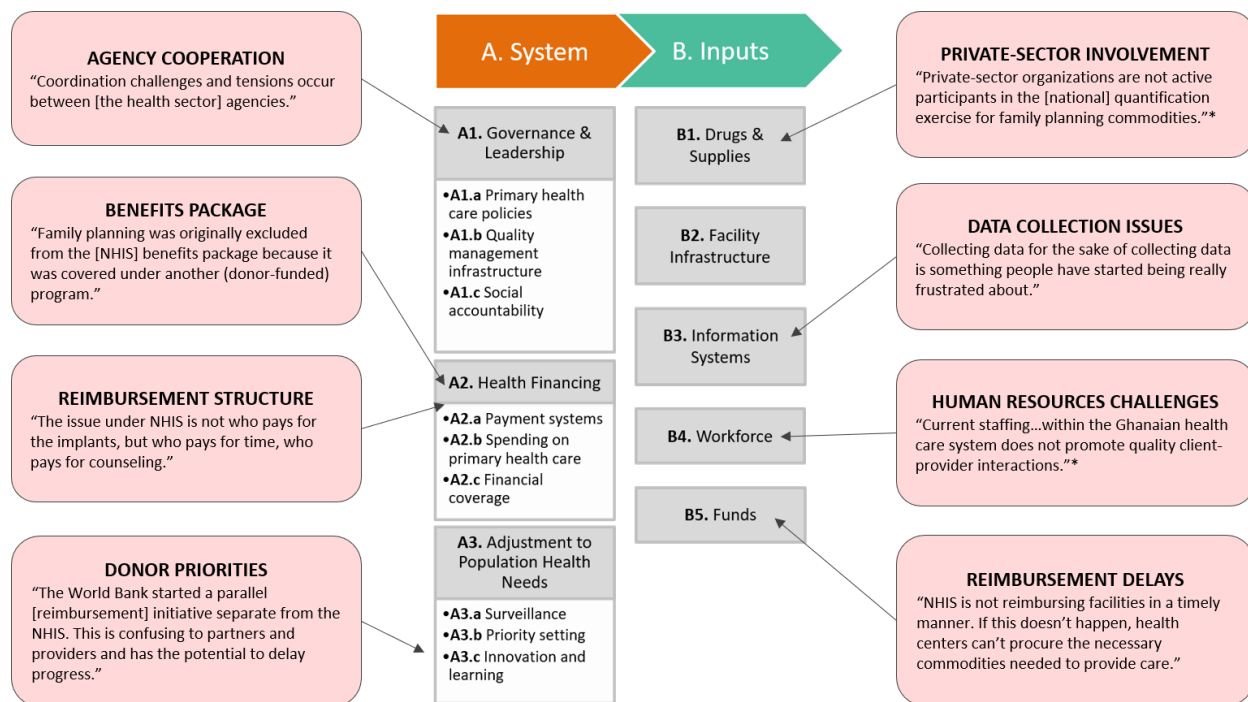
Delays in NHIS reimbursements to providers for family planning services are an obstacle to integration and could derail the NHIS pilot. Several interviewees described such delays and their effects on provider behavior. One expert said that reimbursement delays lead some providers to charge clients out of pocket for services so they can be certain to recover their costs.

Other interviewees said that delays in NHIS reimbursements can impede the provision of services. External donors cover only family planning commodities, so some facilities cannot afford other consumables, such as gloves and syringes, that are necessary to provide long-acting methods and injectables. As a result, facilities offer limited choice to clients.

Delays in reimbursements may also pose an obstacle to scaling up the NHIS pilot. One interviewee noted: “Reimbursements are a key challenge as the pilot program kicks off, since the NHIS is trying to use provider payments to shape behavior at the service delivery level.” Another interviewee noted that when the NHIS piloted capitated payments for providers, payments were more likely to be made on time than under fee-for-service reimbursement.

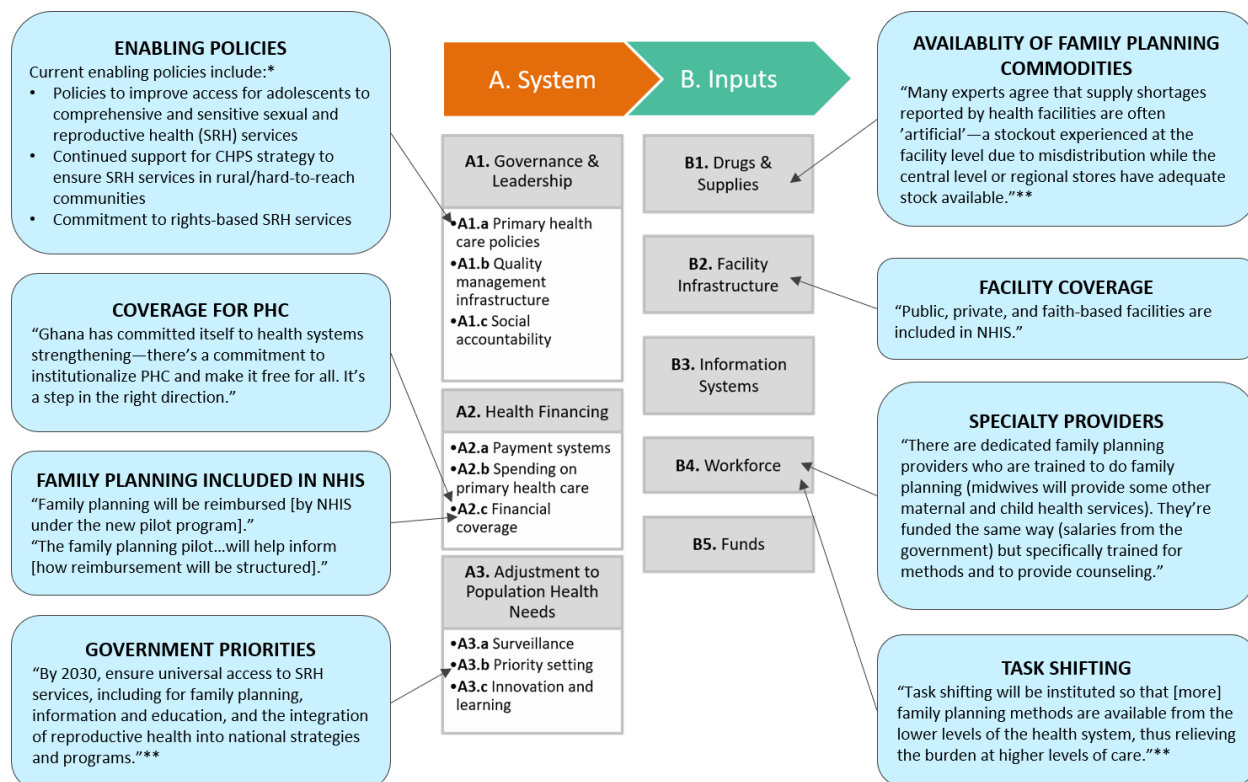
Figures 7 and 8 summarize the key obstacles and enablers, respectively, for integration of family planning and PHC at the System and Input levels.

Figure 7. Key Obstacles to Integration (System and Input Components)



* Source: Ghana Family Planning Costed Implementation Plan, 2016–2020
All other comments are from interviews with health sector stakeholders in Ghana.

Figure 8. Key Enablers of Integration (System and Input Components)



* Sources: Ghana Family Planning Costed Implementation Plan 2016–2020, National Community-Based Health Planning and Services Policy, Adolescent Health Service Policy and Strategy (2016–2020)

** Source: Ghana Family Planning Costed Implementation Plan 2016–2020

All other comments are from interviews with health sector stakeholders in Ghana.

C. Service Delivery

C1. Population Health Management

Family planning is central to the CHPS strategy, but service delivery could be improved by promoting linkages among health facilities, services based at CHPS compounds, and community outreach family planning services.³⁰ Ongoing efforts to create demand for family planning are also needed, as well as efforts to ensure that supply can meet demand.

Community outreach services are critical to increasing family planning uptake and increasing demand. One interviewee noted a need “to address perceptions of family planning among the clients, not just payers and providers” and to address “the emotional component” in health promotion.

Interviewees also reported that clients sometimes avoid obtaining services at CHPS compounds in favor of health centers or hospitals because of lack of choice and capacity at the CHPS level. The GFPCIP acknowledges that increasing capacity at the CHPS level and improving family planning services on offer through outreach or community-based services are critical to reaching the FP2020 commitments.

C2. Facility Organization & Management

Increasing all health workers' clinical and management skills—especially those at the CHPS level and in the private sector—through improved supportive supervision is a key aspect of the GFPCIP strategy and is essential for further integration. GHS has also been emphasizing supportive supervision more broadly and recently released new guidelines that provide continuous training and supportive supervision for delivery of all health services.

Team-based service provision can help increase efficiency and facilitate integration. Family planning programs have typically been housed in discrete sections within facilities and staffed by dedicated providers, so other facility staff have not participated in providing family planning within the broader aspects of care. Ensuring and documenting supportive supervision will help maintain quality when family planning is further integrated with PHC.

C3. Access

Ensuring access to all contraceptive methods is essential to the successful integration of family planning into PHC. Interviewees noted three determinants of access: socioeconomic status, geography, and age.

In Ghana, 24% of the population lives in poverty, which means that covering family planning under the NHIS would relieve the financial burden on eligible clients who currently pay out-of-pocket for family planning services and increase their access.³¹ PMA2020 data indicate that unmet need for modern family planning is highest among the lowest wealth quintile. One interviewee noted that up-front costs can affect a client's choice of method despite the potential for long-term savings: "A client can get six rounds [of injectable contraception] for the cost of one implant."

In terms of geographic access and the ability to obtain same-day family planning services, most facilities in Ghana—both public and private—provide family planning services five or more days per week. Nevertheless, the government wants to make it a priority to ensure "special times" to serve high-need populations, such as adolescents.³²

C4. Availability of Effective Services

More than half of health care delivery points in Ghana offer family planning services during all of their open hours,³³ but these providers may not offer all family planning methods.³⁴ The latest data from PMA2020 show that 99% of public facilities surveyed offered three or more types of methods and 72% offered five or more methods. Most of those offering three methods offered only short-acting methods, while those offering five or more methods included long-acting reversible contraceptives.

Interviewees mentioned lack of provider motivation as an obstacle to further integrating family planning with PHC. Providers often recommend short-acting methods, which are easier to administer, rather than those that might best suit a client's needs.

Provider competence is another impediment to integration. As one interviewee said, "providers' technical capacity gets lost" when they don't have a lot of clients who request long-acting methods. Many providers also lack training in insertion and removal of long-acting methods, which limits the range of methods offered.

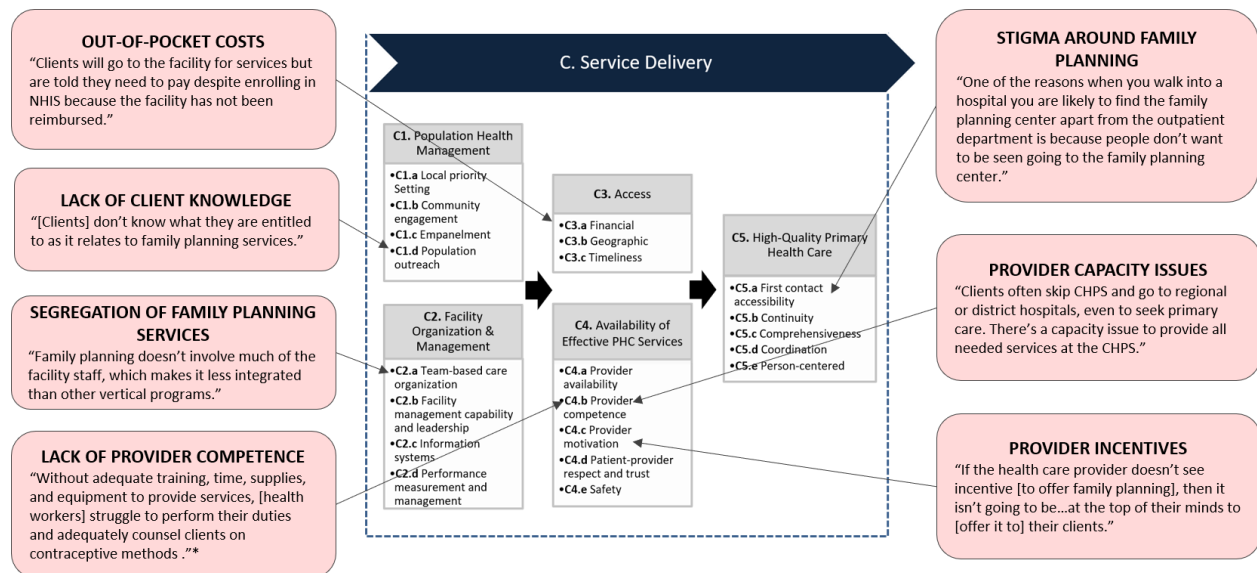
C5. High-Quality Primary Health Care

Informed choice is essential to high-quality family planning service delivery. Interviewees described “information asymmetry” in family planning, whereby most clients are unaware of the range of methods available to them and the benefits and potential side effects of each method. They are thus heavily reliant on information from providers. When providers are unable or unwilling to counsel on all methods, clients lack true informed choice.

Stigma is also a consideration in the discussion of integration. Health care providers can play a significant role in shaping clients’ views on family planning and decreasing stigma. One interviewee said that the cultural dynamics around family planning are such that people tended to associate family planning with abortion. Routinely integrating family planning into PHC services would help demonstrate that comprehensive health care includes family planning and would broaden client perceptions about what family planning entails. The 2014 Ghana Demographic and Health Survey (DHS) found that more than 60% of women in all age groups did not discuss family planning when visited by a health worker or when going to a health facility.

Figures 9 and 10 summarize the key obstacles and enablers, respectively, of integration of family planning and PHC at the Service Delivery level.

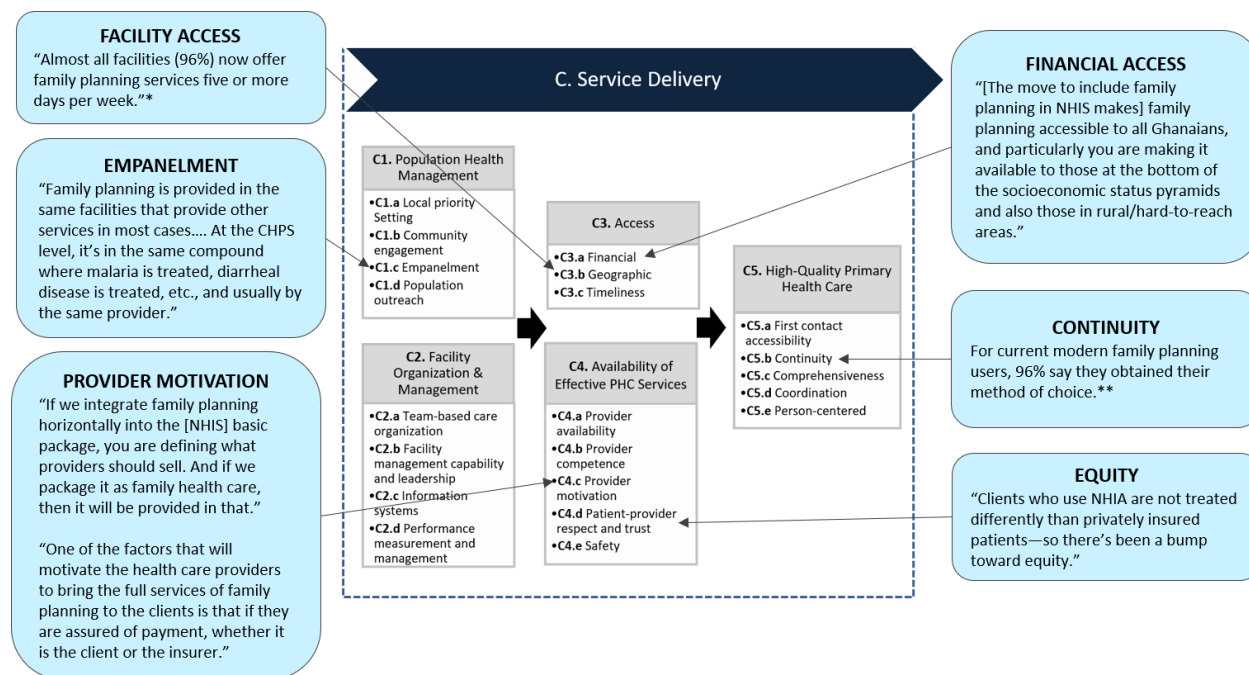
Figure 9. Key Obstacles to Integration (Service Delivery Components)



* Source: Ghana Family Planning Costed Implementation Plan 2016–2020

All other comments are from interviews with health sector stakeholders in Ghana.

Figure 10. Key Enablers of Integration (Service Delivery Components)



* Sources: Ghana Trend Analysis for Family Planning Services 1993, 1996, 2002, and 2005; PMA2020, “Family Planning Brief: Ghana (September–November 2017)”

** Source: PMA2020, “Family Planning Brief: Ghana (September–November 2017)”

All other comments are from interviews with health sector stakeholders in Ghana.

Usefulness of the PHC Framework for Mapping Points of Integration

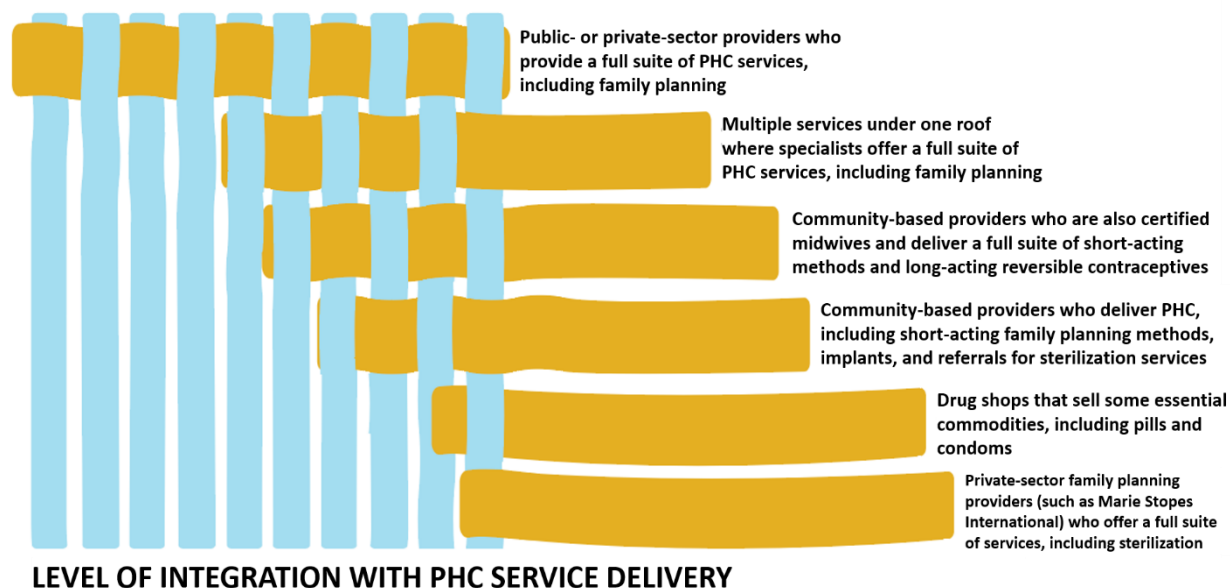
The PHC Conceptual Framework has been useful for mapping the points of integration between family planning and PHC programs in Ghana, by providing a way to organize and help identify patterns in the data sources we examined. However, many important data points are linked to multiple components of the framework. For example, slow reimbursement processes (A2. Health Financing) can impede the ability of facilities to buy needed commodities (B5. Funds), which in turn means that clients are charged for services that should be free (C3. Access). Due to the complexity of these chains of events, coding and organizing data according to the framework could lead to redundancies or prevent proper contextualization of how these processes work. Importantly, informed choice, which is central to quality family planning services, cannot be captured neatly by any one component of the framework.

The Next Step: Considering Integration Options

Mapping the family planning program in Ghana using the PHC Conceptual Framework is one way to identify discrete points where integration is more desirable or less desirable, depending on the goals of the vertical program and PHC program stakeholders. It also helps illuminate the continuum of integration. Figure 11 illustrates the degree to which family planning is already integrated into PHC in various service delivery settings in Ghana. In some settings, the PHC provider offers a full suite of family planning services, which we define as including counseling, provision of the full range of family planning methods, appropriate health education, and sexual health services that include testing for HIV and sexually transmitted infections. The least integrated setting is a standalone private-sector facility that

offers only family planning services and no other PHC services. Facilities of this type tend to be fractional franchisees, where services are added to an existing medical practice and supported by social franchising organizations such as Marie Stopes International and Population Services International.

Figure 11. Continuum of Integration Across Ghanaian Health Services



Creating an Inclusive Process for Identifying Integration Priorities

Successful decisions about integration require stakeholders from different sectors and from different levels of the health system to agree on a set of priorities that reflect what is most feasible and desirable for the country context and will help the country reach its stated goals. Integration is never a full system overhaul, but it can better connect vertical programming and PHC.

We created a checklist-style tool for donors and policymakers to identify where integration goals are included in the national strategy and how much progress has been made. Policymakers can then determine where integration is desirable and chart progress over time.

The Ghana checklist was completed using information from the interviews with health experts, strategy documents, and other background literature. Figure 12 shows a simplified version; the Annex provides a more complete version that includes comments to help policymakers understand the assigned status levels.

Figure 12. Ghana’s Integration Priorities

Ghana’s Integration Priorities				
PHC Conceptual Framework	Integration Pathway			
		○ None ◐ Partial ● Full	Presence in National Strategy	Current Status
A. System	Alignment between government, donors, and partners on PHC/FP integration priorities	○	○	○
	Guidelines developed and approved for PHC and FP, including counseling and informed choice	●	●	●
	A1. Governance & Leadership			
	Integrated supportive supervision to assess service provision and quality for PHC and FP	●	○	○
	Agency structures that reflect shared priorities between PHC and FP	●	◐	◐
	Single mechanism at a national level to coordinate PHC/FP integration	●	●	●
	A2. Health Financing			
	Costed implementation plan that includes PHC/FP integration	●	◐	◐
	Covered benefits package/national insurance scheme that covers PHC and FP	●	◐	◐
	A3. Adjustment to Population Health Needs	Appropriate targeting to address unmet need	●	◐
B. Inputs	B1. Drugs & Supplies	Unified supply chain, including appropriate forecasting mechanism	●	○
	B2. Facility Infrastructure	Private-sector facilities in PHC/FP network	●	◐
	B3. Information Systems	Shared registers and reporting system for PHC and FP	○	○
	B4. Workforce	Task shifting to expand network for eligible providers for long-acting reversible contraceptives	●	●
C. Service Delivery	C3. Access	FP services offered during all service hours	●	●
	C4. Availability of Effective PHC Services	Regular training for providers on FP	●	◐
		Sufficient staffing to provide both PHC and FP, including counseling on informed choice	●	◐
	C5. High-Quality Primary Health Care	Adequate facility space and equipment to provide integrated services	●	◐
		Clients able to receive most appropriate method on site or through referral	●	◐

Looking Ahead at Integration Priorities for Ghana

As noted earlier, integration is not an all-or-nothing or all-at-once shift. Ghana’s national government, its Ministry of Health, and GHS have shown a clear commitment to scaling up family planning coverage and meeting the country’s ambitious FP2020 commitments. The country has also dedicated time and resources to developing sound family planning policy and a national strategy that includes several key points of integration with PHC. Feasible next steps for Ghana would be to incorporate the missing policy considerations and move the partially implemented items forward. Given its stated priorities, the government is likely to focus on only a few key items in the checklist in the near term.

For example, as Ghana transitions out of donor funding, the government wants to build a resilient and self-funded health system. A number of interviewees stressed the importance of better aligning government agencies, donors, and other stakeholders and covering family planning services through the NHIS. In this case, the following checklist items warrant the greatest attention:

- Alignment between government, donors, and partners on PHC & FP integration priorities (A1. Governance & Leadership)
- Covered benefits package / national insurance scheme that covers PHC & FP (A2. Health Financing)

Cooperation and alignment among stakeholders would help lead to more efficient resource distribution and more timely policy implementation. Timely reimbursement of comprehensive family planning services through the NHIS would remove up-front cost barriers for clients and motivate providers to offer high-quality family planning, including the full suite of services to ensure informed choice for clients. The current situation, with reimbursement delays and lack of utilization reporting within the NHIS, must be improved to ensure that the NHIS can be an effective vehicle for family planning coverage. This would help ensure that family planning services are cost effective over the long term, which is critical to ensuring NHIS solvency.

Annex: Ghana's Integration Priorities

The following checklist was completed using information from interviews with health experts, strategy documents, and other background literature. This figure is a more complete version of the checklist shown in Figure 12 and includes comments to help policymakers understand the assigned status levels.

Ghana's Integration Priorities					
PHC Conceptual Framework	Integration Pathway	Presence in National Strategy			
		None	Partial		
		Full	Current Status		
A. System	A1. Governance & Leadership	Alignment between government, donors, and partners on PHC/FP integration priorities	<input type="radio"/>	<input type="radio"/>	Rationale for Status Multiple interviewees said that government, donors, and partners have different ideas about how to include FP in NHS. Key PHC delivery model is CHS; guidelines for providing FP services and informed consent counseling are included in guidelines. GFPICP outlines "integrated supportive supervision model," but this is not yet active on the ground. GFPICP outlines multisectoral committee for contraceptive security, but interviewees mentioned tensions between MOH and NHS and between MOH and MOF in priority setting. GFPICP states unequivocally that MOH is the coordinating body for all health services. GFPICP includes FP/PHC integration as a priority. Pilot program to determine reimbursement models for FP services under NHS is ongoing in selected districts. GFPICP outlines strategies for reaching populations with most unmet need and is working toward this through CHS and the NHS FP pilot. GFPICP has a goal to include the private sector in supply chain, but interviewees said no significant progress has been made toward this goal. Private-sector providers are included under NHS, and the FP pilot will include private-sector providers in selected districts. GFPICP makes no mention of combining registers and data systems. Interviewees said that data collection tools are still vertical. GFPICP calls for continued support for task shifting. CHS now trained and authorized to provide implants. Latest PMA2020 data indicate good availability of FP during regular service hours. GFPICP also committed to expanding access to FP during off-hours to increase access. GFPICP documents the need for better FP-relevant equipment availability at service delivery points. Literature suggests there is adequate space for privacy and counseling. PMA2020 data indicate that almost all facilities stock at least three methods and many stock five methods. However, only half of health centers stock five methods, so there is room for improvement in available method mix.
		Guidelines developed and approved for PHC and FP, including counseling and informed choice	<input type="radio"/>	<input type="radio"/>	
		Integrated supportive supervision to assess service provision and quality for PHC and FP	<input type="radio"/>	<input type="radio"/>	
		Agency structures that reflect shared priorities between PHC and FP	<input type="radio"/>	<input type="radio"/>	
		Single mechanism at a national level to coordinate PHC/FP integration	<input type="radio"/>	<input type="radio"/>	
		Costed implementation plan that includes PHC/FP integration	<input type="radio"/>	<input type="radio"/>	
		Covered benefits package/national insurance scheme that covers PHC and FP	<input type="radio"/>	<input type="radio"/>	
		Appropriate targeting to address unmet need	<input type="radio"/>	<input type="radio"/>	
		Unified supply chain, including appropriate forecasting mechanism	<input type="radio"/>	<input type="radio"/>	
		Private-sector facilities in PHC/FP network	<input type="radio"/>	<input type="radio"/>	
B. Inputs	B1. Facility Infrastructure	Shared registers and reporting system for PHC and FP	<input type="radio"/>	<input type="radio"/>	
		Task shifting to expand network for eligible providers for long-acting reversible contraceptives	<input type="radio"/>	<input type="radio"/>	
		FP services offered during all service hours	<input type="radio"/>	<input type="radio"/>	
		Regular training for providers on FP	<input type="radio"/>	<input type="radio"/>	
C. Service Delivery	C3. Access	Sufficient staffing to provide both PHC and FP, including counseling on informed choice	<input type="radio"/>	<input type="radio"/>	
		Adequate facility space and equipment to provide integrated services	<input type="radio"/>	<input type="radio"/>	
		Clients able to receive most appropriate method on site or through referral	<input type="radio"/>	<input type="radio"/>	
C4. Availability of Effective PHC Services	C5. High-Quality Primary Health Care	Regular training for providers on FP	<input type="radio"/>	<input type="radio"/>	
		Sufficient staffing to provide both PHC and FP, including counseling on informed choice	<input type="radio"/>	<input type="radio"/>	

Endnotes

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